



Medical professionals use a tool called the SOAP method to gather and record information. Read the following description of a SOAP note (*adapted from Wikipedia*):

The **SOAP note** (an acronym for **subjective, objective, assessment, and plan**) is a method of documentation employed by health care providers to write out notes in a patient's chart. Documenting patient encounters in the medical record is an essential procedure. Prehospital care providers such as EMTs may use the same format to communicate patient information to emergency department clinicians. Podiatrists, Chiropractors, Physical Therapists, Massage Therapists, among other providers use this format for the patient's initial visit and to monitor progress during follow-up care.

### **Subjective component**

Initially is the patient's **Chief Complaint, or CC**. This is a very brief statement of the patient (quoted) as to the purpose of the office visit or hospitalization. If this is the first time a physician is seeing a patient, the physician will take a **History of Present Illness, or HPI**. This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative symptoms under **review of body systems**. **Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies**, are also recorded.

### **Objective component**

The *objective* component includes:

- Vital signs (pulse, respiration, blood pressure) and measurements, such as weight and height
- Findings from physical examinations, including basic systems of cardiac and respiratory, the affected systems, possible involvement of other systems, pertinent normal findings and abnormalities.
- Results from laboratory and other diagnostic tests already completed.

### **Assessment**

A medical diagnosis for the purpose of the medical visit on the given date of the note written is a quick summary of the patient with main symptoms/diagnosis including a differential diagnosis, a list of other possible diagnoses usually in order of most likely to least likely. It is the patient's progress since the last visit, and overall progress towards the patient's goal from the physician's perspective.

### **Plan**

This is what the health care provider will do to treat the patient's concerns - such as ordering further labs, radiological work up, referrals given, procedures performed, medications given and education provided. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.



A SOAP note may be organized in many different ways. Below is a guided template to organize the information that we will use to begin our first patient case study. Review each category and the information that fits within each heading.

<b>SOAP Notes - Definitions</b>	
<b>Subjective:</b>	
<b>Signs &amp; Symptoms</b>	Patient's chief (primary) complaint (CC); major evidence of the problem
<b>Allergies</b>	Any improper reaction of the body to food/medicine/plants/animals
<b>Medications</b>	Any medicines the patient is currently taking.
<b>Past medical history (Social, Family)</b>	Relationship status, family history of illnesses/disorders, any significant social or behavioral patterns or events, past history of the problem, etc.
<b>Last oral intake</b>	Food last eaten, with time and description.
<b>Events leading to injury or illness</b>	What was happening at the time of the injury/illness/problem.
<b>Frequency</b>	How often the symptoms occur.
<b>Associated Symptoms</b>	Not the major complaint, but any other signs or symptoms of the disorder.
<b>Radiation</b>	Places the pain/symptoms travel or spread to.
<b>Character</b>	Description of the pain. Rating on a scale of 1-10.
<b>Onset</b>	When the symptoms or episode(s) first began.
<b>Location</b>	Place(s) of symptoms in the body.
<b>Duration</b>	How long the symptoms last.
<b>Exacerbating Factors</b>	Things that make the symptoms worse.
<b>Relieving Factors</b>	Things that make the symptoms better.
<b>Objective:</b>	
<b>Measurements</b>	Weight, Height, Age, Gender
<b>Vital Signs</b>	Blood Pressure, Body Temperature, Respiratory rate, Heart rate (pulse)
<b>Physical Exam Results</b>	Findings of visual and physical exam; record any findings using sight, touch, listening, smell
<b>Lab Results</b>	Can test any body fluid (blood, saliva, semen, urine, stool) for many things: (ex: cholesterol, bacteria, blood sugar, etc.); Can also do visual imaging (ex: ultrasound, MRI, echocardiogram, etc.)

<b>Assessment:</b>	
<b>Summary</b>	Short summary of patient and chief complaint
<b>Diagnosis</b>	Final conclusion about what the problem is (including a brief summary of supporting evidence)
<b>Differential Diagnosis List</b>	Other possible diagnoses (usually listed in order from most likely to least likely)
<b>Plan:</b>	
<b>Plan steps:</b>	Any care (treatment or preventative) that addresses the problem. Should be comprehensive, including both short- and long-term plans and addressing all relevant components of health (mental, social, and physical). Also includes any prescriptions or over-the-counter medications, procedures to be performed, referrals, or advice and directions given to the patient. States when a follow-up visit will be required.

In order to understand how to record subjective and objective data, assessment information, and the treatment plan, review the example on the following page. As you read through each section, list any questions you have or helpful tips to remember in the spaces below:

<b>Subjective</b>	
<b>Objective</b>	
<b>Assessment</b>	
<b>Plan</b>	



**Post-Reading Questions:** Answer the following questions based on the reading:

1. What are SOAP notes and why are they used?
2. What are the differences between the **Subjective** and **Objective** sections?
3. What are the main components of the **Assessment** section?
4. What do you think differentiates a successful and effective **Plan** from an unsuccessful or ineffective one?

**Post-Reading Check:** Fill in the appropriate section for each description below.

- ① \_\_\_\_\_ These are things the patient tells you. These **observations** include the patient's descriptions of pain or discomfort, the presence of nausea or dizziness, when the problem first started, and any other descriptions of dysfunction, discomfort, or illness the patient describes.
- ② \_\_\_\_\_ These observations include symptoms that can actually be measured, seen, heard, touched, felt, or smelled. Included in objective observations are vital signs such as temperature, pulse, respiration, skin color, swelling and the results of diagnostic tests.
- ③ \_\_\_\_\_ This is the diagnosis of the patient's condition. In some cases the diagnosis may be clear, such as a contusion. However, an assessment may not be clear and could include several diagnosis possibilities.
- ④ \_\_\_\_\_ This may include laboratory tests ordered for the patient, medications ordered, treatments performed (e.g., minor surgery procedure), patient referrals (sending patient to a specialist), patient disposition (e.g., home care, bed rest, short-term, long-term disability, days excused from work, admission to hospital), patient directions (e.g. elevate foot, RTO 1 week), and follow-up directions for the patient.

Adapted from: <http://www.physiciansoapnotes.com/>